



October 31, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madame Secretary:

On behalf of the State of Connecticut, we offer the following comments on proposed rules regarding the Medicaid Program; Eligibility Changes Under the Affordable Care Act (ACA) of 2010 published in the Federal Register on August 17, 2011 pursuant to title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

We appreciate the opportunity to comment on this important regulation and have noted several areas where we believe that additional attention to the proposed rule will result in a final rule that provides clarity for compliance.

In the preamble to this proposed rule CMS seeks comments regarding extending the proposed renewal procedures for modified adjusted gross income (MAGI) - based eligibility to beneficiaries eligible on a basis other than MAGI. We support the idea of extending the renewal procedures in §435.916(a) to beneficiaries eligible for Medicaid other than MAGI-based eligibility. The state also supports the availability of more modernized procedures that could apply to both the MAGI and MAGI-excepted populations. The more consistency between different groups will help make the eligibility process less burdensome for recipients and for program administrators.

The proposed rule provides the requirement that the state Medicaid agency must certify criteria necessary for the Exchange to use to determine Medicaid eligibility based on MAGI. In the preamble to the proposed rule CMS seeks comment on whether the Exchange should be certified to make eligibility determinations for those whose eligibility is based on factors other than MAGI. We do not support providing any other eligibility rules or criteria other than MAGI-based criteria. Specifically, Medicaid eligibility based on criteria other than MAGI is often a difficult and complicated decision. The expertise and experience of the Medicaid agency to accomplish this determination necessitates that the agency not delegate this function.

The proposed rule provides the requirements for coordination of eligibility for individuals who are undergoing a Medicaid eligibility determination on a basis other than MAGI. We concur with CMS comments in the preamble that individuals may enroll in other insurance programs while a final Medicaid eligibility determination is pending.

Under the definitions section 155.300, the Medicaid proposed rule does not specify that FPL is based on the data published as of the first day of the Exchange open enrollment period, which means that the FPL table used in eligibility determinations for Medicaid and CHIP may be different from that used for advance payments of tax credit and cost sharing reductions for the Exchange, depending on the date of eligibility. This will mean that the state will need to use two different FPL tables to determine eligibility; one for Medicaid/CHIP and another for the Exchange. This may present significant administrative difficulties and we urge CMS to simplify this process by using a single FPL table for all eligibility determinations.

Under 155.305, the Exchange will not determine a primary taxpayer to be eligible for advance premium tax credits if the primary taxpayer or his or her spouse did not file a tax return for a year in which he or she received an advance premium tax credit. We urge CMS to consider adding an exclusion for recipients of advance premium tax credits for those who fail to pay their share of the premium or are delinquent in paying their portion of the premium at the time of renewal.

The 90-day grace period included in the law, and further defined in other proposed rules, will unduly burden carriers who are responsible for paying the medical claims of those individuals who fail to pay their share of the monthly premium for up to 90 days; and we have submitted comments on this matter. Allowing these same individuals to re-enroll in coverage, potentially switching carriers and qualified health plans during the open enrollment period, should be prohibited until such time as the taxpayer is no longer delinquent in his or her payments for prior year's coverage.

We are very concerned with the different time periods used to calculate income-based eligibility for Medicaid and CHIP vis-à-vis the Exchange. While Medicaid and CHIP eligibility is based on current income, eligibility for advance premium tax credits is based on annual income. This difference will cause considerable confusion for consumers and eligibility workers, and we urge CMS to consider ways to minimize or eliminate the discrepancy between these two time periods.

Associated with the calculation of income using different time periods, we remain very concerned about the potential liability for individuals and families who may be eligible for advance premium tax credits for part of the year but have a mid-year change in circumstances that results in their becoming ineligible. In some instances, even if these taxpayers correctly notify the Exchange that they are no longer eligible for advance premium tax credits due to a change in circumstances, they will be financially liable due to their receipt of advance premium tax credits when they file their taxes, despite the fact that at the time of receipt of the advance premium tax credits they were eligible for these benefits. The retroactive recovery of advance premium tax credits due to a change in circumstances will cause considerable confusion, will unfairly penalize residents, and may undermine the ability of the Exchange to attract consumers.

With regard to the notification of eligibility determination, section 155.310 (f), we would appreciate clarification with regard to “timely notice” and whether the Exchange may notify an individual through electronic means (e.g., PDF or other type of electronic communication) in lieu of written (hard copy) notification. Particularly for those applicants that utilize an on-line eligibility process, we are looking to streamline this notification process and believe there are administrative and cost efficiencies to be achieved by allowing electronic notification, with a paper-based notification available only upon request of the applicant.

With regard to section 155.315(e), the preamble notes that “like all other eligibility determinations, an eligibility determination in accordance with paragraph (e)(5)(i) of this section is subject to appeal.” We interpret this to mean that individuals disputing their eligibility or advance premium tax credits through the Exchange will have the same appeal rights as those required of the Medicaid and CHIP programs. This could cause significant administrative burdens and cost to the state and the Exchange, and we urge CMS to consider granting state Exchanges some flexibility in the process used to handle appeals for advance premium tax credits that are less onerous than those required of Medicaid and CHIP eligibility appeals.

With regard to section 155.320 (e), concerning verification related to eligibility for qualifying coverage in an employer-sponsored plan, the proposed rule directs the Exchange to require an applicant to attest to his or her eligibility for qualifying coverage in an eligible employer-sponsored plan. We are concerned that employees that decline coverage in an employer-sponsored plan at the time of the employer’s open enrollment may subsequently apply for coverage through the Exchange and indicate that they are not eligible for coverage under the employer’s plan. We request clarification as to whether employees that were eligible for coverage in an eligible employer-sponsored plan but declined coverage during the employer’s open enrollment period would be deemed eligible for coverage through the Exchange; or whether those employees would be precluded from enrolling in coverage through the Exchange. We also request clarification with regard to eligibility for advance premium tax credits for people who are on COBRA. Enrollment in COBRA could be interpreted to mean that the individual is eligible for coverage under an employer’s plan, and therefore potentially ineligible for coverage through the Exchange. Even if the COBRA premiums do not exceed 9.5% of the person’s modified adjusted gross income, we believe COBRA-eligible individuals should be allowed access to the Exchange and the applicable advance premium tax credits.

Section 155.330(e)(3) would require the Exchange, and by extension the qualified health plan issuers, to maintain an individual’s enrollment for a full month after the month in which the determination notice has been sent by the Exchange, although advance payments of the premium tax credit and cost-sharing reductions will be discontinued. We are concerned that this provision could cause confusion and duplication of coverage, and we urge CMS not to dictate this level of specificity in the regulations, but rather leave it to the states, in concert with the QHP issuers, to establish a policy pertaining to continuation of coverage.

With regard to the request for comment on whether Exchanges should determine all eligibility at a consistent time of the year or on a rolling basis, we suggest that you allow each state to determine how best to re-determine eligibility and not prescribe either a consistent time of the year or a rolling basis, but rather defer this policy to the states.

We appreciate the opportunity to comment on these proposed regulations and look forward to working with you on the implementation of health reform that provides access to affordable health coverage for the residents and businesses of Connecticut.

Sincerely,

A handwritten signature in black ink, appearing to read "Nancy Wyman". The signature is fluid and cursive, with the first name "Nancy" written in a larger, more prominent script than the last name "Wyman".

Nancy Wyman
Lieutenant Governor
State of Connecticut